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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar epidural steroid injection at left L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Diplomate, American Board of Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

The Official Disability Guidelines criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male with a reported work related injury to his lumbar. The patient was getting out of the car and as soon as he stepped up, he had severe back pain and left leg pain.

2014: On December 12, 2014, a magnetic resonance imaging of the lumbar spine was performed. The clinical history was lumbar strain and sciatica. The findings revealed left paracentral disc herniation at L5-S1. The patient was utilizing acetaminophen, atorvastatin, cyclobenzaprine, Percocet, prednisone and tramadol. There was protruding disc material resulting in slight posterior displacement of the crossing left S1 nerve root although there was no frank nerve root compression shown at the current time. Per addendum, there was mild multilevel degenerative disc disease from L3-S1, most prominent at L5-S1 where there was moderate broad-based left-sided protrusion contributing to significant left lateral recess narrowing which would account for left radiculopathy.

On December 17, 2014, evaluated the patient for low back pain radiating down to the left buttocks, back of thigh and back of the calf to bottom of his feet. The pain was rated at 10/10 most of the time and was aggravated by movement. He had history of back surgery. Examination revealed him to be miserable. He was walking step by step. Standing caused him more pain. He was uncomfortable. Straight leg raising (SLR) on the right side caused left-sided back pain going down his left buttocks. SLR on left was very difficulty. The MRI was reviewed. diagnosed work-related acute onset of back pain and left leg pain. There was soft disc herniation. The patient was recommended left-sided L5-S1 ESI first and then could participate in physical therapy (PT). Percocet was prescribed. The option of left-sided microdiscectomy was given. He was kept off work until injection.

2015: On January 11, 2015, noted the patient continued with persistent left-sided back pain radiating down to left buttocks and left thigh and calf. The diagnosis was acute sciatica. did not think injection would help him very much, however, recommended proceeding with the injection at left L5 as planned. If no improvement, left L5 discectomy was to be offered.

On January 28, 2015, gave him a choice again and noted eventually he might consider left L5-S1 microdiscectomy plus and L4-L5 decompression without discectomy. The patient still was not better and recommended considering second opinion to concur the concern.

On February 5, 2015, the patient was seen at for ongoing complaints of arm pain, mid back pain, low back pain, buttocks pain and leg pain. The patient was recommended second ESI.

On February 6, 2015, saw the patient for a second opinion regarding further treatment. The patient complained of pain that was fairly global in his leg, but included posterior thigh posterior calf to lateral aspect of this foot. There was pain and numbness. He was not getting better and rated pain at 8/10. He was utilizing atorvastatin, cyclobenzaprine, ondansetron, pantoprazole and Percocet. Examination of lumbar spine revealed tenderness to light palpation with flexion/extension extremely limited. He was not able to walk on heal or toe due to pain. There was decreased fine touch at L4-L5 and S1. Flip low back pain was positive. noted the patient had left leg sciatica and small disc protrusion at L5-S1 on the left and had multiple Waddell signs. recommended left-sided microdiscectomy to be reasonable.

On February 18, 2015, noted the patient had about 20% relief for three days from the ESI dated January 5, 2015. The patient was resistant in having surgery. He had seen for a second opinion and he recommended more injections. recommended second injection and CT myelogram prior to any surgical intervention.

On March 9, 2015, CT lumbar myelogram revealed minor changes of spondylosis at the L4-L5 and L5-S1 level. There was no lateralizing disc herniation or

significant canal narrowing at any level. No adverse changes since December 19, 2012.

On March 18, 2015, noted the patient had severe pain in the left side of back. The patient received 30% relief from the second epidural steroid injection (ESI) that was given in the prior week. There was positive straight leg raise (SLR) on left. MRI showed disc herniation at L5-S1. The CT myelogram was reviewed. Walking caused more pain. The diagnosis was acute sciatica, herniated disc, and displacement of lumbar disc without myelopathy. recommended third ESI for the lumbar spine. He noted that surgery could be a good option of left-sided L4-S1 microdiscectomy to help him go back to work.

Per telephonic conversation dated April 7, 2015, the patient stated he received about 30% relief from the second ESI. He wanted to proceed with the third and was requesting refills on Percocet and Flexeril. The patient was prescribed Percocet and recommended third lumbar ESI at left L5 level.

Per utilization review dated April 13, 2015, the request for lumbar epidural steroid injection at L5-S1 was denied with the following rationale: *"The request for lumbar epidural steroid injections at left L5-S1 #3 is not medically necessary. The claimant has had persistent back and leg pain. There was 20-30% improvement for one week with the second injection and, no relief with the first injection. The claimant had no significant stenosis on imaging. The request does not meet evidence based guidelines. Therefore, the request for lumbar epidural steroid injections at left L5-S1 #3 is not medically necessary."*

On April 29, 2015, noted the patient continued with persistent symptoms. Prolonged sitting, standing and walking caused more pain. He was unable to walk a block due to increased pain. noted the patient had no relief from the first injection, but had 40-45% relief from the second injection given on March 11, 2015, for five weeks. The patient wanted another shot. recommended seeing a pain management if he did not want surgical intervention.

On April 30, 2015, appealed for the third ESI and recommended the patient eh might seek some employment that was sedentary and lift <20 lbs and not his regular driving job. The patient was getting depressed staying at home and he might need some anti-depressant medications to help deal with this.

Per reconsideration review dated May 5, 2015, the appeal for lumbar ESI at L5-S1 was denied with the following rationale: *"This patient is a male and was injured in xx/xx/xx. The patient noted an acute onset of left leg pain when he got out of the car. The patient subsequently was treated conservatively with physical therapy which was of no benefit. The patient then underwent an epidural steroid injection (ESI) January 6, 2015, that provided 20% relief for three days. The patient subsequently underwent a second epidural steroid injection which provided 20-30% relief. Another ESI is being requested. The request for lumbar ESI to left L5-S1 #3 was not certified. Per ODG, we recommend no more than 2 ESI injection for the initial phase and rarely more than 2 for therapeutic treatment.*

ODG does not recommend a series of 3 ESI and only recommends repeat injection when the patient has received at least 50% benefit for 6-8 weeks. As such, this request is not medically necessary. Therefore, with the information given above, the requested lumbar ESI is not certified."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Documentation does not support a repeat injection per ODG.

Criteria for the use of Epidural steroid injections:
Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.
(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs).
(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.
(4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.
(5) No more than two nerve root levels should be injected using transforaminal blocks.
(6) No more than one interlaminar level should be injected at one session.
(7) *Therapeutic phase:* If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)
(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.
(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.
(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**